Bellmawr Board of Education

Medical Coverage Selections - Schools Health Insurance Fund/Aetna

Who Can Select This Plan?	All Employees	All Employees
	NJ Educators Health Plan	**Garden State Plan (NJ Network Only)**
In-Network Benefits	**In Network**	**In-Network**
Deductible	$0 Individual	$0 Individual
	$0 Family	$0 Family
Out of Pocket Limit	$500 Individual	$500 Individual
	$1,000 Family	$1,000 Family
Primary Care	$10 copay	$10 copay
Specialist	$15 copay	$15 copay
Preventive	No Charge	No Charge
Diagnostic (x-ray, blood work)	No Charge	No Charge
Imaging (CT/PET scans, MRIs)	No Charge	No Charge
Outpatient Surgery	No Charge	No Charge
Emergency Room	$125 copay	$125 copay
Emergency Transportation	90% covered	90% covered
Urgent Care	$15 copay	$15 copay
Durable Medical Equipment	90% covered	90% covered
Hospital Stay	No Charge	No Charge
Eye Exams (1 Exam/Calendar Year)	$15 Copay	$15 Copay
Vision Hardware Reimbursement	Not Applicable	Not Applicable
Out of Network Benefits	**Out of Network**	**Out of Network**
Deductible	$350 Ind/$700 Family	$350 Ind/$700 Family
Coinsurance	70% after deductible	70% after deductible
Out of Pocket Limit	$2,000 Ind/$5,000 Family	$2,000 Ind/$5,000 Family

-Preauthorization may be required for certain services.

-GSP is a Network of NJ Providers only. Out of state services will not be covered unless it is a true medical emergency.

-For the NJEHP & GSP, the employee's contribution is based on the new salary based contribution schedule. For all other plans, your employee contribution will remain the same per your collective bargaining agreement.

-This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical plans. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.

Bellmawr Board of Education

Prescription Coverage Selections - Schools Health Insurance Fund/Express Scripts

Who Can Select This Plan?	**All Employees**
	NJ Educators Health Plan & Garden State Plan
Retail Copays (Up to 30 day Supply)	
Generic	$5 Copay
Brand Name Drug (Generic Alternative Not Available)	$10 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**
Mail Order (Up to 90 day Supply)	
Generic	$10 Copay
Brand Name Drug (Generic Alternative Not Available)	$20 Copay
Brand Name Drug (Generic Alternative Available)	Member Pays the Difference**
Additional Features	
*Step Therapy	Applies
**Mandatory Generic	Applies
***Mail Order for Specialty Medications	Applies
****Closed Formulary	Applies

*Step Therapy- Where more than one medication in a certain drug class has been shown to be clinically effective but a varying costs, Step Therapy requires a trial with the lower cost medication before approval of the higher cost medication, where clinically appropriate.

**Mandatory Generics- The pharmacist must dispense the generic equivalent medication when one is available. If the member fills the brand name drug instead, they will be responsible for the brand copay plus the difference in cost between the generic and brand name drug.

***Accredo is the specialty pharmacy for Express Scripts. Specialty pharmaceuticals typically require special handling and patient monitoring.

****Closed Formulary - Certain medications are excluded from the covered drug list. A great majority of brand-name medications and generic medications are included in the formulary. All conditions with excluded medications have covered clinically equivalent medications. Please note, the formulary may change throughout the year, and for a copy of the most up to date version, please refer to Express Scripts website: https://www.express-scripts.com/

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical, prescription, dental, and vision programs. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.

Bellmawr Board of Education

Dental & Vision Coverage Selections

Delta Dental Premier Plan

Preventive & Diagnostic - Covered 100%

(exams, cleanings, x-rays)

Basic Services - Covered 70% after deductible

(Fillings, extractions, endodontics, periodontics, sealants)

Crowns & Prosthodontics - Covered 50% after deductible

(crowns, bridgework, repairs, dentures, inlays)

Calendar Year Maximum - $1,500.00

Calendar Year Deductible - $50 Individual / $150 Family

Orthodontia (Dependent Children Only)

Full Comprehensive Treatment - Covered 50%

Maximum (Lifetime) - $1,500.00

VSP Vision Plan

Exam - $25 Copay / Once every 12 months

Frames - $130 allowance / once every 24 months

Lenses -Single vision, lined bifocal, and lined trifocal every 24 months; combined with exam

Contact Lenses (instead of frames) - $130 allowance every 24 months, $60 copay

Lens Enhancements Savings

Laser Vision Correction Discounts

This overview is being provided as a convenient reference tool and is not a complete overview of the benefits being offered through your medical, prescription, dental, and vision programs. Some plan limitations may apply. Please refer to the plan documents provided by your carriers for detailed plan information. If there is any discrepancy between the descriptions of the program elements in this overview and the official plan documents, the language of the official plan documents shall prevail as accurate.